Working with Sexual Offenders with Intellectual Disabilities

Transforming Care for Individuals with Learning Disability & Complex Needs Conference

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"Take your time Mr Jenkins and try to identify the individual who broke into your home."
Shameless self promotion!!

Craig, Lindsay & Browne, (2010)
De-institutionalisation

Epidemiology

- There have been a noticeable increase in offenders with ID in criminal justice settings (real or perceived?).

- Community care policies in the Western World represents a decrease in the provisions of custodial care for people with learning disabilities (Lindsay, 2004).

- There are more people with ID who have forensic problems living in the community and fewer individuals placed in large locked/secure institutions.

- As a result, there has been a doubling incidence of sex offending among ID between 1973 and 1984 (Lund, 1990).
Lindsay et al (2011): 20 yr referral follow up comty forensic ID service. (N= 309)

- Sig increase in referrals from criminal justice services
- Sig decrease from community services
- Greater court/police involvement with people with ID.
Accurate estimations?


- Up to 7% of the prison population is learning disabled and a further 23% of prisoners are "borderline" (PRT, 2006).

- April 2015 in custody 81,740, of which 11,600 for sexual offences. 7% increase from 2014.

- Based on Mottram’s (2007) estimations, there could be as many as , 3,380 sexual offenders with ID currently in prisons.
Prevalence

- The rate of sex offence charges nearly twice as high amongst ID defendants than non-ID defendants (Hawk et al. 1993).

- Offenders with ID are more likely to commit violence (including rape and child molestation) compared to non-ID offenders (Hodgins, 1992).

- 41% engage in challenging behaviours defined as ‘sex related’, of which 17% had police contact and 4% were convicted of sexual offences (McBrien et al., 2002).

- Between 21% and 50% of offenders with ID had committed a sexual crime (Gross, 1985).

- 28% of 33 men with an ID detained under hospital orders had committed a sexual offence (Walker & McCabe, 1973).
Prevalence: Caveat

- It would be inaccurate to take the figures from various stages in the criminal justice system at face value.

- Filters involved at each stage (e.g., before anyone is reported, prior to any charge, before cases are brought before the court, and before sentencing, etc.)

- The higher prevalence may be due to:
  - Misinterpretation of behaviours
  - Increased visibility of offenders with ID where the commission of their offences is often less sophisticated.

- There is no evidence for the over or under-representation of people with ID amongst sex offenders - methodological differences are so great that it is difficult to draw any firm conclusions (Lindsay et al. 2002).
Counterfeit-Deviance Hypothesis
Deviant behaviour precipitated by lack of sexual knowledge, poor social skills, limited opportunities, sexual naivety.

Sexual Abuse
Assumes an association with sexual abuse in childhood and sexual offending.

Impulsivity
Assumes that sexual offenders with learning disabilities will be more impulsive than their non-disabled counterparts.

Lack of Discrimination Hypothesis
Persistent sexual offending is a result of deviant sexual interests, mediated by distortions and selective cues.
Hypotheses of Offending

Counterfeit-Deviance Hypothesis:

Lack of Evidence:

- Rice et al (2008): compared sexual offenders with ID and non-ID on PPG
  - Sexual offenders with ID displayed deviant sexual interest prepubertal children, male children and young children.
  - Sexual offenders with ID were no more likely to exhibit preferences for extreme coercion or deviant adult activity preferences.

- Sex offenders with ID display deviant sexual arousal and cognitive distortions (Murphy, et al. 1983).
Counterfeit Deviance - Sexual Knowledge. Sex Offenders V Non Sex Offenders.
Sample: people with ID: sexual and non-sexual (Michie et al, 2006 - SA:JRT)
Hypotheses of Offending

Counterfeit-Deviance Hypothesis:

- Talbot & Langdon (2006). No significant difference between untreated sex offenders with ID and non-offenders with ID.
  - Limited sexual knowledge unlikely to be a factor placing men with ID at risk of committing sexual offences

- Lunsky et al (2007): sexual offenders with ID had higher levels of sexual knowledge than non-offenders

- Lindsay (2009): revision:
  - sexual offenders with ID knowledge are considerably poorer than that required by non-handicapped men...
  - they may not have full comprehension of the extent of offending in society – coupled with sexual interests, this may lead to offending.
Hypotheses of Offending

**Counterfeit-Deviance Hypothesis:**

- Griffiths et al. (2013). Update: ISB might be precipitated by:
  - lack of sexual knowledge,
  - poor social and interpersonal skills,
  - limited opportunities to establish appropriate sexual relationships and
  - sexual naiveté

rather than deviant sexual interest.
Hypotheses of Offending

Sexual Abuse:

- Lindsay et al., (2001) compared the physical and sexual abuse histories of 46 sexual and 48 non-sexual offenders with learning disabilities

  - 38% of the sexual offenders and 12.7% of the non-sexual offenders had experienced sexual abuse.

  - while 13% of the sexual offenders and 33% of the non-sexual offenders had experienced physical abuse.

- Few existing studies on sexual abuse in people with ID suggest behavioural problems (sexual disinhibition) as a consequence of sexual abuse (Seueira & Hollins, 2003).

- Lack of standardisation and controls makes any conclusion speculative (Lindsay, 2004).
Abuse in childhood in offenders with ID (Lindsay et al., 2011) - reviewed the sexual and physical abuse histories of 156 male sex offenders with (ID), 126 non-sexual male offenders with ID and 27 female offenders with ID.
Hypotheses of Offending

**Mental Illness:**

- 32% of sexual offenders with ID had suffered psychiatric illness (Day, 1994; Lindsay et al. 2002).

- However, Lund (1990) reported that 91.7% (87.5% categorised as behaviour disorders) had a diagnosis of MI in a sample of 274 mixed LD offenders.

- Variations in definitions of mental illness may account for this discrepancy as behaviour disorders were reported separately in both the Day and Lindsay studies (Lindsey, 2004).

- However, MI is negatively associated with sexual offending (i.e., protective factor in VRAG/SORAG)
Hypotheses of Offending

**Impulsivity:**

- Levels of impulsivity in sexual offenders with ID compared with those of non-ID sexual offenders revealed no significant differences (Lindsay & Parry, 2003).

- Similarly, no differences in educational history, childhood disturbances, adolescent history, contact with psychiatric services or the number of previous charges for sex crimes (Glaser & Deane, 1999).

- Little evidence that sexual offenders with ID are anymore impulsive with regard to their offending as they demonstrate delayed gratification through the display of simple grooming behaviours (Lindsay, 2004).
Hypotheses of Offending

Lack of Discrimination Hypothesis:

- SO/ID are less discriminating in their victims.
  - 68% had previous for offending (Scorzelli et al, 1979).
  - 62% had previous sexual offending (Lindsay et al. 2002).
  - 33% offences against adults, 28% against children, 18% exposure.

- Sex offenders with ID tend to:
  - have low specificity for age and sex of their victims (Gilby et al., 1989; Griffiths et al., 1985),
  - have a greater tendency to offend against male children and younger children (Blanchard, Watson, & Choy, 1999; Brown & Stein, 1997; Rice et al, 2008).
Offender Characteristics

- Sex offenders with ID may have:
  - Higher incidence of family psychopathology
  - Psycho-social deprivation,
  - Behavioural disturbances at school,
  - Psychiatric illness,
  - Social and sexual naivety,
  - Poor ability to form normal sexual and personal relationships,
  - Poor impulse control
  - Lower levels of conceptual / abstract reasoning

Pathways to Offending

Offending Pathways (Ward & Hudson, 1998)

- Avoidant active: actively avoids offending
- Avoidant passive: prefers not to offend but does little to stop
- Approach explicit: active and seeking opportunities
- Approach automatic: while motivated, more opportunistic

No sig difference between offenders with ID and mainstream offenders across pathways.
Sex offending pathways

(Langdon, Maxted and Murphy, 2007: JIDD)

**Active/Explicit**
- Higher IQ
- Greater sex knowledge
- Lower QACSO

**Approach**
- Higher IQ
- Greater denial

![Bar chart showing sex offending pathways with categories and corresponding data points](chart.png)
Sex offending pathways
Lindsay et al (2008). N=62 sex offenders with ID

Active/Explicit
- Higher IQ (IQ 68 v 64).
- More contact offences
Sex offending pathways
Lindsay et al (2008). N=62 sex offenders with ID
Bickley & Beech (2002). N=87 child molesters
Recidivism Risk

- Appropriate engagement alone will not produce reduction in recidivism

- Treatment in isolation (institution) is unlikely to produce gains in recidivism

- Both are needed – address primary motivation and social engagement

(Lindsay, 2011)
Recidivism

- Offenders with ID were 5x times more likely to commit a violent offence (incl: rape and molestation: Hodgins, 1992).

- Day (1993; 1994) found that re-offending was more likely to occur in the first year following discharge.

- Klimecki et al., (1994) 84% of overall re-offending occurred within the first 12-months. However, several individuals who had received prison sentences for sex offences were still incarcerated.

- Of 93 patients with ID, 72% re-offended in 10 years (Lund, 1990).
Recidivism

- Gibbens and Robertson (1983) reported a reconviction rate of 68% in 250 male patients with ID detained under hospital orders.

- Barron et al. (2004) followed 61 offenders with ID referred to specialist mental health and criminal justice services.

  - LD offenders start offending at an early age, had a history of multiple offences, and that sexual and arson offences were over-represented.

  - At follow-up approximately half of the sample had re-offended.
Risk factors associated with sexual reoffending in sex offenders with ID. (Elliot, Lindsay & Astell, 2004). N=52,

- Poor response to treatment, $r=0.45$**
- Poor compliance with man/treat routine, $r=0.415$*
- Allowances made by staff, $r=0.409$**
- Low self-esteem, $r=0.374$**
- Poor relationship with mother, $r=0.346$*
- Denial of Crime, $r=0.335$*
- Sexual abuse, $r=0.327$*
- Anti-social attitude, $r=0.309$*
- Low treatment motivation, $r=0.303$*
- Offence involving violence, $r=0.295$*
- Juvenile crime, $r=0.284$*
Sexual Reconviction Rates

- Klimecki et al., (1994) re-offending rate of 41.3% in prison inmates with ID at a 2-year, and 34% recidivism for sexual offenders.

- 84% of overall re-offending occurred within the first 12-months following discharge (Day, 1993; 1994)

- Lindsay (2002): 4% re-offended in 12-months and 21% in 4 years.

Differences between studies:
- Definitions: Lindsay et al (re-offending), Klimecki et al (re-offence).

- Lindsay et al - treatment for SO/LD in community setting whereas Klimecki et al study based on offenders with LD held in a prison setting.
Recidivism

Craig et al. (2008): UK reconviction for non-ID SO.
- Incarcerated sample: 2 yrs (6.0%), 4 yrs (7.8%), 6+ yrs (19.5%).
- Non-incarcerated sample: 2 yrs (5.7%), 4 yrs (5.9%), and 6+ yrs (15.5%).
- Overall sexual reconviction rate combined: 5.8% at 2 yrs, and 17.5% at 6 years or more.

Using Klimecki et al.’s (1994) re-offence rate of 34% at 2-years, and Lindsay et al.’s (2002) re-offence rate of 21% at 4-years.

Craig & Hutchinson (2005) estimated sex offenders with ID reoffend:
- 6x that of non-ID sexual offenders at 2-years
- 3x that of non-ID sexual offenders at 4-years
Assessing Risk

Possible Risks

1422. Alien Invasion
1423. City destroyed by angry Monkey God
1424. Building eaten by giant pig.

“Well he certainly does a very thorough risk analysis.”
Methods of Assessing Risk

7 methods of risk assessment

**Clinical Judgement**
- Unstructured professional judgement
- Structured professional judgement (e.g., HCR-20)
- Anamnestic assessment
- Research guided clinical judgement
- Clinically adjusted actuarial approach

**Actuarial Assessment**
- Actuarial use of tests
- Actuarial risk instruments
Actuarial Scales

- RRASOR (Hanson, 1997)
- Static-99/2002R (Hanson & Thornton, 2000)
- SORAG (see Quinsey et al, 1998)
- VRAG (see Quinsey et al, 1998)

Clinically Guided Risk Measure

- SVR-20 (Boer et al, 1997)
- HCR-20 (Webster et al, 1997/2013)
- RSVP (Hart, Kropp et al, 2002)
- PCL-R: Psychopathy measure (Hare, 1991)
Actuarial Risk Scales

**ARAIs: shared characteristics**

- ARAIs represent highly structured risk assessment scales using combinations of empirically determined and thoroughly operationalized predictor variables.

- Predictor items (correlated with sexual recidivism).

- Scores correspond to risk categories (low, medium, high).

- ‘Experience tables’ (retrospective studies) indicate a prediction of future risk.

- Probabilistic estimate extracted: 45% for an individual of risk over a 10-year period.
<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Codes</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior sex offences</td>
<td>Charges</td>
<td></td>
</tr>
<tr>
<td></td>
<td>None</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>1-2</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>3-5</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>6+</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Convictions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>None</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>2-3</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>4+</td>
<td>3</td>
</tr>
<tr>
<td>Prior sentencing</td>
<td>3 or less</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>4 or more</td>
<td>1</td>
</tr>
<tr>
<td>Any conviction for non-contact sex offences</td>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>Index offence non-sex violence</td>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>Prior non-sex violence</td>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>Any unrelated victims</td>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>Any stranger victim</td>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>Any male victims</td>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>Young</td>
<td>Aged 25 or older</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Aged 18 to under 25</td>
<td>1</td>
</tr>
<tr>
<td>Single</td>
<td>Lived with lover for at least 2 years</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>1</td>
</tr>
</tbody>
</table>

**Static-99**
(Hanson & Thornton, 2000)

**Risk Categories**

0-1 = Low

2,3 = Medium-Low

4,5 = Medium-High

6+ = High
Actuarial Risk: Caveat

- Sexual offenders with ID have:
  - Reduced opportunity to establish meaningful relationships
  - More likely to be diverted from the criminal justice system

- Actuarial risk measures include, number of previous criminal convictions and relationships history.
  - RRASOR (Hanson, 1997)
  - Static-99 (Hanson & Thornton, 2000)

- Actuarial measures may not accurately estimate the risk of those offenders diverted from the mental health services to criminal justice system.
Do you get the feeling we are missing something?

WHY DO YOU HAVE ONLY 40% OF AN UMBRELLA?

CHANCE OF RAIN IS ONLY 40%
Structured Professional Judgement

HCR-20 V3 (Webster et al., 1997/2013)

- 20 items plus any case specific factors assess clinical evaluations of sexual risk across a broad range of populations and settings
**HCR-20**

**HCR – 20 V3** (Webster *et al.*, 1997/2013)

Assess clinical evaluations of sexual risk across a broad range of populations and settings in 3 domains:

<table>
<thead>
<tr>
<th>Historical Items</th>
<th>Clinical Scales</th>
<th>Risk Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>H1: Violence</td>
<td>C1: Recent Problems with Insight</td>
<td>R1: Professional Services and Plans</td>
</tr>
<tr>
<td>H2: Other Antisocial Behaviour</td>
<td>C2: Violent Ideation or Intent</td>
<td>R2: Living Situation</td>
</tr>
<tr>
<td>H3: Relationships</td>
<td>C3: Symptoms of Major Mental Disorder</td>
<td>R3: Personal Support</td>
</tr>
<tr>
<td>H4: Employment</td>
<td>C4: Instability</td>
<td>R4: Treatment or Supervision Response</td>
</tr>
<tr>
<td>H5: Substance Use</td>
<td>C5: Treatment or Supervision Response</td>
<td>R5: Stress or Coping</td>
</tr>
<tr>
<td>H6: Major Mental Disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H7: Personality Disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H8: Traumatic Experiences</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H9: Violent Attitudes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H10: Treatment or Supervision Response</td>
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<td></td>
</tr>
</tbody>
</table>

Boer *et al* (2010) - suggested revised scoring / coding system for offenders with ID
ARAIs with SO with ID (AUC) (Lindsay, Hogue et al, 2008) N=212 across 3 levels of security and community. Recorded sexual or violent incidents

$M-IQ$ range 66-64.
Assessment of Risk Manageability for Individuals with Developmental and Intellectual Limitations who Offend (ARMIDILLO) (Boer, Lindsay et al, 2006)
ARMIDILO

ARMIDILO comprised of management items only.

The ARMIDILO, used with an actuarial test and an appropriate structured clinical guideline (SVR-20 or RSVP), is part of an assessment procedure which combines the assessment of risk and risk manageability in one assessment.

The items in the ARMIDILO are distributed amongst:
- staff/environment and
- client dynamic factors,

both of which are further differentiated into
- stable and
- acute dynamic groups.
What’s different in the ARMIDILIO

- Some items in the standard SO/VO scales are simply not applicable (e.g., employment), or defined suitably (e.g., relationships).

- Boer et al, have added a large number of items related to the environment and staff involved with the client that are clearly new and not used in any other structured guideline tests.

- Mostly dynamic and have borrowed liberally from the STABLE and SONAR scales of Hanson, et al.
Item classification

1. Stable Dynamic Items (staff and environment).
2. Acute Dynamic Items (staff and environment).

All items are as related to risk as they are to manageability in institutional or community settings.

Each assessment will require the assessor to determine which variables are of most relevance to their client and determine which items is or is not indicative of elevated risk for the client.
Sexual Deviancy

- PPG – rarely used

- Psychometric assessment (Deviancy Domains: Craig & Lindsay, 2010)

- Social and Emotional Continuum
Structured Assessment of Risk and Need and Responsivity (SARNR)

- A structured clinical judgment measure of the dynamic risk propensities (psychological characteristics) for sexual offending

- 15 risk factors over four domains
  - Sexual Interests
  - Offence Supportive Attitudes
  - Relationships/Socio-affective functioning
  - Self-Management

- In 2013 a new domain for protective factors was included (3 factors). Two risk factors included

- Generality (G) and offence chain (OC) coding
<table>
<thead>
<tr>
<th>Sexual Interests Domain</th>
<th>Offence Chain</th>
<th>Generality</th>
<th>Sexual preference for children</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Obsessed with sex</strong></td>
<td>1. Sexual preoccupation upon release from prison. “I could give her one....I need to empty my ball bag” when referring to XX.</td>
<td>3. Sexual Obsession scores – significant. Rape fantasy and sexual assault (pretreatment) significant.</td>
<td>No evidence</td>
</tr>
<tr>
<td>Some men want to have sex so often and so badly that it feels like an obsession.</td>
<td>2. Over-interpreting staying over at XX – “I think my luck is in tonight....definitely going to have sex”.</td>
<td>4. Previous conviction for attempted rape – similar sexual preoccupation thoughts to that of index offence. Saw victim and thought this “meant he could have sex” as she was a prostitute.</td>
<td></td>
</tr>
<tr>
<td><strong>Offence chain</strong></td>
<td>3. Prior to offence, thought relating to needing sex, masturbation at magazines and thoughts surrounding engaging in the services of a prostitute.</td>
<td>5. Previous short-term relationships – admitted only about sex. Visit prostitute at 19 – all about sex. Masturbation to pornography at 15.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. Prior to commission of offence, thoughts related to needing sex, over-interpreting victim’s actions – “I bet she’s up for it...she wouldn’t have come here otherwise”.</td>
<td>6. At end of relationship with Ms XX, stated was sexually frustrated and considered visiting another prostitute, but no money to do so.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2 – Central to Offence</td>
<td>7. Psychiatric report concludes a disturbance in sexual behaviour and attitudes.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2 – Strongly Characteristic</td>
<td>8. Reports from Ms XX states that he would “pester her for sex”.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>0 – Not Present</td>
<td>9. Sex is important to him. Attempted rape and index offence committed within 6 months of release from prison. No information surrounding level of sexual preoccupation whilst in prison.</td>
<td></td>
</tr>
</tbody>
</table>

Prof Leam A Craig
Adapting the SARNR (Hocken, 2014)

<table>
<thead>
<tr>
<th>Sexual Interests</th>
<th>Thoughts that make offending okay</th>
<th>Relationships</th>
<th>Struggling with life’s problems</th>
<th>Things that keep you safe and give you purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thinking about sex a lot</td>
<td>Thinking men should be in charge in sexual relationships</td>
<td>Feeling lonely, bad about yourself and that you can’t change things</td>
<td>Rushing into things without thinking them through</td>
<td>Actively changing my life for the better by working on the things that led me to offend in the past</td>
</tr>
<tr>
<td>Liking sex with children</td>
<td>Thinking that men should have sex when they want it</td>
<td>Feeling better with children than adults</td>
<td>Not dealing with life’s problems</td>
<td>Being a responsible member of society, sticking to the rules, and getting on with the people who are supporting me</td>
</tr>
<tr>
<td>Liking sex to include violence</td>
<td>Thinking sex with children, or rape, is ok</td>
<td>Feeling angry and suspicious all the time and wanting to get your own back</td>
<td>Having big problems controlling feelings</td>
<td>Having a job or being busy</td>
</tr>
<tr>
<td>Other sexual interests that are related to your offending</td>
<td>Thinking women can’t be trusted</td>
<td>Having close family and friends who commit crime</td>
<td>Not having a close relationship with an adult</td>
<td></td>
</tr>
</tbody>
</table>
Psychological Deviance Index (PDI: Craig et al. 2007)

PDI = Number of Deviancy Domains (0 to 4).

PDI: 2 years follow-up AUC = .75
      5 years follow-up AUC = .69
Craig & Lindsay (2010): Suggest organising psychometric data into the SARN domains for SO with ID.

<table>
<thead>
<tr>
<th>Domains</th>
<th>Psychometric Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual Interests</td>
<td>Multiphasic Sex Inventory - Sexual Obsession and Paraphilia scales</td>
</tr>
<tr>
<td></td>
<td>Sexual Attitudes and Knowledge Assessment (SAK)</td>
</tr>
<tr>
<td>Distorted Attitudes</td>
<td>MSI Cognitive Distortions and Immaturity, and Justifications scales</td>
</tr>
<tr>
<td></td>
<td>Adapted Victim Empathy</td>
</tr>
<tr>
<td></td>
<td>The Adapted Victim Consequences Task - adaptated from the Victim Empathy Questionnaire</td>
</tr>
<tr>
<td></td>
<td>Abel and Becker Cognition Scale</td>
</tr>
<tr>
<td></td>
<td>Questionnaire on Attitudes Consistent with Sexual Offenders (QACSO)</td>
</tr>
<tr>
<td></td>
<td>Sex Offenders Opinion Test</td>
</tr>
<tr>
<td></td>
<td>Sex Offences Self-Appraisal Scale</td>
</tr>
<tr>
<td>Social and Emotional</td>
<td>Adapted Self Esteem Questionnaire - adapted version of Thornton’s Brief Self Esteem Scale</td>
</tr>
<tr>
<td>Functioning</td>
<td>Adapted Emotional Loneliness Scale - adapted from the Russell, Peplan and Cutrona’s (1980)</td>
</tr>
<tr>
<td></td>
<td>UCLA Emotional Loneliness scale</td>
</tr>
<tr>
<td></td>
<td>The Nowicki-Strickland Internal-external Locus of Control Scale</td>
</tr>
<tr>
<td>Self-Management</td>
<td>Adapted Relapse Prevention Interview</td>
</tr>
<tr>
<td></td>
<td>The Psychopathic Checklist-Revised (PCL-R: Hare, 1991) - Factor 2 (adapted by Morrisey, 2003)</td>
</tr>
</tbody>
</table>
RNR


- **RISK**: Providing the treatment intensity proportional to risk level

- **NEED**: Targeting problematic behaviours or criminogenic need (dynamic risk factors)

- **RESPONSIVITY**: tailoring treatment in such a way that the individual will gain the most benefit from it
Coleman and Haaven (2001) describe how inappropriate sexualised behaviour could be misconstrued.

“…a learning disabled person may leave his fly unzipped because he has not been reminded to finish dressing, or because he has hopes of shocking a female carer.

...Although in both cases the person needs to be stopped and redirected, depending on the motivation behind the behaviour.

...the former situation he may benefit from a time limited social skills course training, whereas in the latter situation his may require more intensive sexual offender treatment” (pp 195).
Tell me about these melon-collie feelings.
Treatment

Little progress in made using mainstream programmes

- Difficulty in understanding and processing information leading feelings of frustration and isolation.
- Additional help from other group members and facilitators.
- Difficulty in generalising experiences
- Difficulty grasping concepts, including empathy, and are more concerned about the consequences to themselves.

- Feelings of frustration, impacting on motivation – often misidentified as unmotivated and difficult treatment failures in mainstream programmes.
HMP and ID

*R (D Gill) v Secretary of State*: (High Court Feb 2010).

- Hx: aggression, ABH/Wounding. Several assaults on prison staff. Automatic Life sentence for violence.
- FSIQ=65.
- 1st PB: suitable for ETS, CALM, CSCP.
- 2nd PB: due to literacy problems can’t do groups.
- Further PBs: need to look elsewhere for evidence of reduction in risk (beh in prison, responsibility). Hx of improving behaviour.
- Referral to psychiatric units but unable to transfer (MHA).
- Numerous psychiatric/psychological assessments – need for literacy and adapted interventions.

- Claims against SoS upheld.
- Claims of disability discrimination not upheld.

Treatment

- Few RCT.

- Most are case studies and small groups.

- Clinicians base practice on clinical experience and evidence from non-ID populations.

- Barron et al., (2004) compared the recidivism rates on those who received specialist interventions for ID clients and those who received non-specialist interventions.

- Little evidence for efficacy of interventions that were non-specific to people with ID.
Treatment

- Information pictorially presented, frequently repeated, tested out across time and situation.

- Use of games, role-play – linking emotions and behaviours with thoughts.

- Treatment is less structured/fluid, based on the progress of the group – individual formulation.

- Craig & Hutchinson (2005) - review of the literature reveal typical treatment components:
  - Sex education
  - Challenging cognitive distortions / denial
  - Enhancing victim empathy / self awareness
  - Relationships skills
  - Self control / Relapse Prevention skills
Adapted Measures
Craig & Lindsay (2010) reviewed measures for SO/ID.

The initial / screening assessments:
1. Intellectual functioning (WAIS-IV).
3. Receptive language (British Picture Vocabulary Scale, Dunn, Dunn, Whetton & Burley, 1997
4. Mental health (Psychiatric Assessment for Adults with a Developmental Disability, mini PASADD; Prosser, Moss, Costello, Simpson & Patel, 1997).
5. Autism assessment (The Diagnostic Criteria Checklist; Howlin, 1997)

Measure of treatment targets: before, during and after treatment.
1. Sexual Knowledge (Sexual Attitudes and Knowledge).
2. Distorted Cognitions (Questionnaire on Attitudes Consistent with Sex Offences; QACSO: Lindsay, Carson & Whitefield, 2000;)
Steps to Risk

1. Thinking About it
   How can I stop it

2. Setting it up
   How can I stop it

3. Getting the chance
   How can I stop it

4. Hurting someone
   How can I stop it
1. Warning
Thoughts & wants

2. Warning
Saying its ok

3. Warning
Setting it up

4. Warning
Hurting someone
**SOTSEC-ID**

- **Sex Offender Treatment Services Collaborative – Intellectual Disability.** (SOTSEC-ID): treatment for men with an ID who are at risk of sexual offending (Murphy et al)

- Represents the first attempt to evaluate and standardise a community-based CBT intervention for sexual offenders with LD using appropriate control samples.

**Results:**

- Data for the first five-groups (Murphy et al., 2004). 60% of the men offered treatment were not required to come by law.

- Mean IQ = 60 with about 30% having Asperger’s syndrome.

- Post-course assessment – sig improvements in victim empathy, sexual attitudes and knowledge and a decrease in cognitive distortions.
SOTSEC-ID (Murphy et al., 2010)
N = 46 (9% reoffending)
Treatment

Craig et al. (2012). Community Probation treatment group.
Avg age 35 years. $M$-IQ = 73
British Vocab = 14.12 years
Vineland's (social & adaptive) = 14.01 years
Craig et al (2012) probation group

QACSO Subscales: Pre- Post- Treatment

* P < 0.05  ** P< 0.01
ASOTP: Community

- N = 14, Mean IQ = 73.

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<thead>
<tr>
<th>Table II</th>
<th>Victim empathy scale scores pre- and post-group</th>
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<tr>
<td></td>
<td>Pre-group</td>
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<tr>
<td>Scale</td>
<td>M</td>
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<tr>
<td>Victim empathy</td>
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Notes: Significant at: *p < 0.01 level; means and standard deviations (n = 12)
Treatment progress. Responses on QACSO Rape scale
(Lindsay, Michie et al 2011 JARID)
Responses on QACSO Offences against children scale
(Lindsay, Michie et al 2011 JARID)

F. U. 6 Years
Reoffending – 23%
Rose et al. (2012): community LD services (n= 12)
IQ ($M$) = 58 (range 49-70)
18mth follow-up: 1 participant re-offended

LoC: more external, but the measure was not adapted for client group.
Summary 1

- Cognitive based therapy for men with ID who commit sex offences needs to be lengthy
  - treatment groups expected run for a minimum of one year
  - significantly better outcomes for sex offenders treated for two years have been reported (Day, 1994; Lindsay & Smith, 1998).

- Without RCT evidence demonstrating treatment effectiveness for SO/ID, clinicians will have to continue to base practice on clinical experience and evidence from non-disabled populations.
In some studies, the sexual recidivism rate of offenders with ID is 6 times and 3 times that of non-ID sexual offenders at 2-years and 4-years follow-up respectively.

Sexual offenders with ID at greater risk of re-offending in a shorter time period – most likely a question of community support.

Actuarial measures may overestimate the risk.
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